# Palforzia
# Peanut (Arachis hypogaea) allergen powder-dnfp

| Member and Medication Information (required) | |
|---|---|
| Member ID: | Member Name: |
| DOB: | Weight: |
| Medication Name/ Strength: | Dose: |
| Directions for use: | |

| Provider Information (required) | | |
|---|---|---|
| Name: | NPI: | Specialty: |
| Contact Person: | Office Phone: | Office Fax: |

**FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED LETTER OF MEDICAL NECESSITY TO 855-828-4992**

**Criteria for Approval: (ALL criteria must be met)**

- ❑ Select the dosage request:
  - ❑ Initial Dose Escalation: 4 to 17 years of age.
  - ❑ Up-Dosing and Maintenance: 4 years of age and older.
- ❑ Medication prescribed by or in documented consultation with an allergy and immunology specialist.
- ❑ Documented clinical history of allergy to peanut or peanut containing foods
- ❑ Confirmed **diagnosis of peanut allergy** documented in chart notes: Chart Note Page #: _____

**Attestation:**

- ❑ Member does NOT have any of the following:
  - Uncontrolled asthma or long-term use of systemic corticosteroid therapy for the treatment of asthma.
  - Diagnosis or symptoms of eosinophilic esophagitis or other eosinophilic gastrointestinal disease.
- ❑ Healthcare setting, prescriber, and dispensing pharmacy are certified in the Palforzia REMS program, and patient is enrolled in Palforzia REMS program.
- ❑ Prescriber has counseled patient to maintain a strict peanut-free diet while taking Palforzia.
- ❑ Patient must have active, unexpired injectable epinephrine, is instructed and trained on its appropriate use, and to seek immediate medical care upon its use.
- ❑ Patient will be observed during and after administration of the Initial Dose Escalation and the first dose of each Up-Dosing level, for at least 60 minutes.

**Re-authorization Criteria:**
Updated letter of medical necessity or updated chart notes demonstrating tolerance of the medication.

**Initial Authorization:** Up to six (6) months

**Re-authorization:** Up to one (1) year

**PROVIDER CERTIFICATION**
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date